Table 1 classifies the respondents by "continuing use"/"discontinued use" categories and lists the frequency of problems and the previous contraceptive experience of each group.

Discussion

Certainly, with only 36 respondents it is impossible to draw conclusions from these data. Students using a student health service are more likely to have a complaint, leaving those who are satisfied with the sponge and "problem-free" underrepresented.

These data suggest, however, that the frequency of problems associated with the contraceptive sponge may be higher than previously reported. Of particular concern is the large percentage of women who had trouble removing the sponge. If removal of the sponge is delayed, the risk of toxic shock syndrome may be increased.

Because the sponge is available over-the-counter without a prescription, it is important for all physicians treating patients who might be sponge users to be familiar with its benefits and risks. Experience in our population, though limited, indicates a relatively high likelihood of sponge-related problems.

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Allergy as a Cause of Recurrent Headaches

TO THE EDITOR: I find an urgent need to comment on the article "Headache—Diagnosis and Effective Management" by Dr K. S. Peters in the June 1984 issue.[1]

I have observed over the years that patients generally are at a serious disadvantage because specialists in fields other than clinical allergy fail to recognize allergic involvement in many conditions. I suggest that such specialists—and I include those who treat headaches—resemble the proverbial blind men examining their first elephant and describing the part they feel as the whole animal. Allergy is a systemic or constitutional condition that finds expression in many areas. Recurrent headache is one of these areas and the literature abounds with reports of headaches with clear specific relationships to allergens. Dr Peters does not refer to allergy as a cause of headache. Cluster headaches, mentioned by Dr Peters, have been reported by others as occurring in the spring or fall seasons yet the author fails to consider the allergic implications.

Each treatment suggested by Dr Peters is symptomatic. There is no therapeutic attention to etiology. The fact that it is possible to treat recurrent headaches from allergic causes effectively with relief of symptoms certainly suggests that the possibility be entertained and proper historical questioning be applied.

Dr Peters is not alone in his neglect of this important consideration. It is high time to correct such neglect.

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Nephrotic Syndrome Associated With Degenerating Uterine Leiomyoma

TO THE EDITOR: The nephrotic syndrome has been associated with a large number of possible etiologic factors including many infections and neoplasms.[1] Uterine leiomyomas have been associated with systemic manifestations.[2] To our knowledge the case presented below represents the first published case of nephrotic syndrome developing in association with a degenerating uterine leiomyoma.

Report of a Case

A 33-year-old woman (gravida 5, para 2 0 3 2) was admitted to the Oroville (California) Hospital and Medical Center with the complaint of severe right lower quadrant pain of 12 days' duration. Her last menstrual period was approximately one month before admission. She had had two abortions and one miscarriage, but none recently. Six years before admission she had been sterilized laparoscopically. Menstrual pattern had been normal. There was a five-year history of hypothyroidism, for which she was taking two grains of thyroid daily. She had had peripheral edema one month before, which resolved when she took diuretics given her by a friend. The pain of which she complained was initially so excruciating that the referring doctor considered a diagnosis of appendicitis.

On physical examination the uterus was noted to be enlarged to 12 weeks' size and was exquisitely tender on movement and direct palpation of the right parametrial area. Vital signs were initially within normal limits and she was afebrile except for one temperature of 37.8°C (100°F). Findings on examination were otherwise normal and specifically there was no peripheral edema. Analysis of urine showed proteinuria (4+); no abnormalities were noted on microscopic examination of urine except for a few leukocytes and rare granular casts. A 24-hour urine study showed protein loss of 22 grams. Serum total protein was 4.4 grams per dl with serum albumin value 2.1 grams per dl. Serum creatinine concentration was within normal limits and creatinine clearance was 149 ml per minute.

Hemoglobin was 14.3 grams per dl. Leukocyte count and differential were normal. Sedimentation rate, corrected, was 44 mm per hour and an antinuclear antibody study was positive with a speckled pattern to a